

Life Insurance Company of North America
Personal Accident Insurance

POLICYHOLDER
State of Tennessee, County of Shelby, Shelby County Government

POLICY No.
OK 980209

Complete the following to enroll:

Full Name _____ Date of Birth ____/____/____
PRINT FULL NAME(S)
Address _____ Social Security # ____-____-____
STREET

CITY STATE ZIP

Select Coverage Option ☐ Employee Spouse ☐ at 50% of my benefit ☐ Children at 50% of my benefit
My Benefit Amount \$ _____ Total Cost \$ _____/per month

My Beneficiary _____ Relationship _____
You will be your family members' beneficiary unless you tell us otherwise in writing.

I enroll and authorize my employer to deduct the premiums from my earnings. I understand that the insurance selected will begin on the effective date as described in the brochure. If I am not actively at work, or my family members are not actively at work, or they are unable to engage in all the usual duties of a person of like age and sex, the effective date of coverage will be delayed until the individual returns to work, or the family member resumes usual duties.

SIGNATURE _____ DATE ____/____/____

☐ **DECLINATION** — Check here and sign above if you do not want this coverage.

Return to your employer. Be sure to make a copy for your records.

TL-007113



CIGNA Group Insurance
Life • Accident • Disability